

1.0 Description of the Procedure

Scanning laser glaucoma tests (SLGT) allow early detection of glaucoma damage to the nerve fiber layer or optic nerve of the eye before there is visual field loss. The SLGT analyzes the nerve fiber layer in the posterior portion of the eye using a confocal scanning laser ophthalmoscope and/or polarimetry. When appropriately used in the management of glaucoma or glaucoma suspect, therapy can be initiated before there is irreversible loss of vision.

2.0 Eligible Recipients

2.1 General Provisions

Medicaid recipients may have service restrictions due to their eligibility category that would make them ineligible for this service.

2.2 Special Provisions

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that provides recipients under the age of 21 with medically necessary health care to correct or ameliorate a defect, physical or mental illness or a condition identified through a screening examination. While there is no requirement that the service, product or procedure be included in the State Medicaid Plan, it must be listed in the federal law at 42 U.S.C. § 1396d(a). Service limitations on scope, amount or frequency described in this coverage policy do not apply if the product, service or procedure is medically necessary.

The Division of Medical Assistance's policy instructions pertaining to EPSDT are available online at <http://www.dhhs.state.nc.us/dma/prov.htm>.

3.0 When the Procedure is Covered

1. SLGT is covered to diagnose early glaucoma and monitor glaucoma treatment.
2. The primary diagnosis on the claim must support medical necessity.

4.0 When the Procedure is Not Covered

SLGT is not covered when the coverage criteria in **Section 3.0** are not met.

Additionally, SLGT is not covered:

1. to further validate a diagnosis, which has been confirmed through earlier detection.
2. for recipients with "advanced damage." Visual fields should be performed.
3. when performed in the absence of an indication as denoted by one of the diagnoses listed in **Section 8.2**.
4. when performed as screening.

5.0 Requirements for and Limitations on Coverage

1. Pre-glaucoma recipients or those with "mild damage" may receive one SLGT per eye per year.
2. Recipients with "moderate damage" may receive up to two SLGTs per eye per year OR one SLGT per eye and one visual fields per year if medically necessary. When both tests are performed, only one of each test is covered per year.
3. Complete ophthalmology examination describing the indications supporting medical necessity must be documented in the medical record. The documentation must include evidence of the following:
 - glaucoma-suspect or mild glaucomatous damage:
 - anomalous appearing optic nerve
 - intraocular pressure > 22 mmHg as measured by applanation
 - symmetric or vertically elongated cup enlargement, neural rim intact, cup to disc ratio > 4.0
 - focal optic disk notch
 - optic disk hemorrhage or history of optic disk hemorrhage
 - nasal step or small paracentral or arcuate scotoma
 - mild constriction of visual field isopters
 - moderate glaucomatous damage:
 - enlarged optic cup with neural rim remaining but sloped or pale, cup to disc ratio > 0.5, but < 0.9
 - definite focal notch with thinning of the neural rim
 - definite glaucomatous visual field defect, e.g., arcuate or paracentral scotoma, nasal step, pencil wedge, or constriction of isopters
4. The following CPT codes are not separately billable with an SLGT:

92225	92226	92250	76512
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6.0 Providers Eligible to Bill for the Procedure

Ophthalmologists and optometrists who perform this service may bill for this service.

7.0 Additional Requirements

There are no additional requirements.

8.0 Billing Guidelines

Reimbursement requires compliance with all Medicaid guidelines including obtaining appropriate referrals for recipients enrolled in Medicaid Managed Care programs.

8.1 Claim Type

Providers bill professional physician services on the CMS-1500 claim form.

8.2 Diagnosis Codes that Support Medical Necessity

Providers must bill the ICD-9-CM diagnosis code to the highest level of specificity that supports medical necessity. The following diagnoses may support medical necessity:

362.85	364.22	364.53	364.73-364.74
364.77	365.00-365.04	365.10-365.15	365.20-365.24
365.31-365.32	365.41-365.44	365.51-365.52	365.59-365.65
365.81-365.82	365.89	365.9	368.40-368.45
377.00-377.04	377.9	743.20-743.22	

8.3 Procedure Codes

The CPT code covered by the N.C. Medicaid program is 92135. When both eyes are tested, bill 92135, 2 units with no modifiers.

8.4 Reimbursement Rate

Providers must bill their usual and customary charges.

9.0 Policy Implementation/Revision Information

Effective Date: January 1, 1999

Revision Information:

Date	Section Revised	Change
9/1/04	5.0	Added medical necessity criteria and limitations relative to visual fields
9/1/05	Section 2.0	A special provision related to EPSDT was added.
12/1/05	Section 2.2	The web address for DMA's EDPST policy instructions was added to this section.